



Mental Health and Disability Services Redesign

Outcomes and Performance Measures Committee Meeting Minutes

Monday, August 20, 2012
Polk County River Place
2309 Euclid Ave.
Des Moines, IA 50319

Attendance:

Members present: Bob Bacon, Diane Diamond, Sen. Joni Ernst, Rep. Joel Fry, Becky Harker, Sen. Jack Hatch, Chris Hoffman, Mike Johannsen, Todd Lange, Geoffrey Lauer, Liz Matney, Rick Shults, Kathy Stone, Carolyn Turvey, David VanNingen, Rep. Cindy Winckler.

Facilitator: Kevin Martone, Technical Assistance Collaborative

DHS Staff: Lauren Erickson, Lin Nibbelink

Other Attendees:

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| Jess Benson | Legislative Services Agency |
| Josh Bronsink | Senate Republicans |
| Deb Eckerman Slack | Iowa State Association of Counties |
| Shannon Evers | Eyerly Ball |
| Kevin Gabbert | Iowa Department of Public Health |
| Jessica Harder | Harder Government Relations |
| Linda Hinton | Iowa State Association of Counties |
| Sandi Hurtado-Peters | Department of Management |
| Sara Lupkes | Polk County Health Services |
| Sherri Nielsen | Easter Seals |
| Liz O'Hara | Center for Disabilities and Development |
| Kelley Pennington | Magellan |
| Cayla Price | Pathways Intern |
| Julie Smith | Iowa Health System |
| Stephen Trefz | Mideastern IA MHC/IACP/ICORN |

Review of last meeting and meeting minutes (Rick)

A working list of outcome domains was developed last meeting based upon committee discussion and public feedback. An objective of this meeting is to narrow the list while still capturing all the main outcome topics that the group feels are important. Rick invited any observations or comments from the last meeting or the notes.

Review of concepts from the first meeting (Kevin)

Important vs. Critical measures

Kevin discussed why various outcome measures may be collected, and may have various levels of importance depending on who the audience is. In the first meeting, outcome measures were discussed in the context as “critical” and “important.”

The distinction between “critical” and “important” can vary depending on your perspective. A measure may be critical to the Department for funding, but not critical to an individual consumer. Or, one consumer may identify a particular measure as critical that another consumer might feel is less important.

Different types of information will be collected throughout this process. We need to think about for whom the outcome is intended. In an ideal world, we’d be able to identify and measures all potential outcomes, but given resource limitations, this group should work to identify a manageable, yet meaningful list of outcome Domains and measures. It is important to note that these can change over time as capacity and experience are developed, and system performance based on evaluation of the outcomes you are measuring drives you add or modify outcome measures.

Process measures and Outcome measurements

Both process and outcome measures are important in a comprehensive performance evaluation system. Systems tend to rely more heavily on process measures: how many people being seen, how many people in a service, etc. An outcome is the effect of that service. An example of a process measure would be a measure of how many people are receiving Assertive Community Treatment (ACT) an evidence-based practice (EBP). This doesn’t tell us how many people are getting better, but by utilizing the EBP and evaluating the programs fidelity to the features that made it an EBP, systems can use the process as an indicator of performance. For example, measuring whether an ACT team has the minimum required staffing and staff: consumer ratio can be a process measure.

Outcomes measures are harder to measure. Outcome measure tells you if people getting better, if the quality of life is improving, if symptoms decrease, etc. Often these are best measured by feedback directly from those who are served through surveys that evaluate specific outcome indicators or measures.

Review of domains and characteristics and Group Discussion

See the handout “Domains for Performance/Outcome Measurement”, available on the MHDS website:

http://www.dhs.state.ia.us/docs/OutcomesAug20Mtg_DomainsFromMeeting1_082112.pdf

Discussion began by emphasizing that these domains are relevant across populations. However, as the group begins to identify specific measures, these may vary depending on the population. The workgroup came up with 10 initial domains during the first meeting, and discussion focused on achieving consensus and narrowing these domains down. For example, a life in the community resonates with everyone. Kevin made the point that we are not going to lose housing or employment, for example, by incorporating them into a Domain. What this does is establishes a framework for the outcomes that you want in the system, and you want to collect the most important things that can tell a story of how well the system is doing.

The workgroup discussed how a “Life in the Community” is an overarching goal that can be made up of multiple factors that reflect Olmstead principles. There was discussion about combining “Quality of Life” and the “Life in the Community” Domain. However, the group noted that there may be quality of life measures that are not in an Olmstead context and cautioned against allowing “Quality of Life” to be overridden by a “Life in the Community”, since different consumers have different needs.

One member proposed the following six Domains:

- Access
- Accountability
- Person Centeredness
- Quality of Life
 - Physical Health
 - Family/Natural Supports
- A Life in the Community
 - Housing
 - Employment
- Safety

Kevin discussed what accountability might mean to different audiences, and whether it should be a stand-alone category or if it could be folded in across all other Domains. The workgroup decided that accountability needs to be a part of every single domain, because each Domain will have different measurements and standards for accountability and stewardship.

Next, the workgroup discussed the importance of integrating physical and mental health care. They discussed how these two cultures are automatically integrated when 40% of our psychiatric drugs are prescribed by primary care doctors, and also discussed the poor morbidity and mortality rate of people with substance abuse and mental health issues when compared to the general population. It was suggested that Health and Wellness be a separate domain to emphasize the importance of routine, bi-directional service delivery to each person with regards to mental and physical health. It was also noted that this is a relatively complex Domain, and the discussion will most likely continue in future meetings.

The workgroup next discussed “Family and Natural Supports”, “Person Centeredness” and “Quality of Life”. There was conversation about incorporating “Person

Centeredness” across Domains since everything we do needs to be person centered. The workgroup ultimately decided that because “Person Centeredness” and “Family/natural supports” are an important overarching philosophy in our system, they needed to be standalone categories. This emphasizes the importance of the individual and their dreams, desires, aspirations, as well as the fact that families often times still provide the bulk of care.

Next, the workgroup discussed “safety” and the importance of how it is defined and applied in people’s lives. It is important that safety does not hinder a person moving forward by closing doors and opportunities, yet we have to know that people are safe in different settings (in the community, Mental Health Institutes (MHIs), Residential Care Facilities (RCFs), etc.). The workgroup agreed that safety is critical, but debated on how to balance the need to know about day to day information (like use of seclusion and restraints in facilities) and the concern about disempowering individuals. It was suggested to combine “Quality of Life” and “Safety” into one Domain as a way to balance the importance of the two.

The workgroup asked how this exercise related to other measurement tools like the NOMS and NCI. The response was that NCI is specific to the DD population only, NOMS is specific to the MH population only, and they don’t necessarily overlap. This group is tasked with trying to find out what is important to collect from a cross-disability perspective in Iowa. This is an exercise of finding out what our priorities are across the entire MHDS system, and then we can look and see where we overlap with the other assessment that we already administer and collect information from.

Kevin summarized where the group is at in terms of narrowing the Domains. This can be modified over the next few meetings, but so far, this is the set of Domains that the group will work from:

1. Access
2. Health/wellness
3. Person Centeredness
4. Quality of life/Safety
5. Life in community
 - Work/meaningful daily activity
 - Housing/integrated living
6. Family/natural supports

Review of examples of outcome and performance measures

The group worked on the Life in the Community Domain and began to identify potential performance measures.

“Life in the Community, Work, Employment”

The goal was to pick one domain and share some work that’s been going on in Iowa to come up with appropriate measures in that domain. There were two handouts: One is a summary of broad, large stakeholder session facilitated by the State Employment Leadership Network (SELN) which was a 3-day culmination of the last three years of work in Iowa. <http://www.dhs.state.ia.us/docs/SELN->

[SummaryEmploymentOutcomeDataDiscussion_082112.pdf](http://www.dhs.state.ia.us/docs/Summary-IA_CoalitionIntegratedEmploymentf_082112.pdf) . The 2nd is a next iteration of those outcomes facilitated by the Iowa Coalition for Integrated Employment (ICIE), a collaboration of the DD Council, Department of Education, Department of Vocational Rehabilitation, and Department of Human Services.

http://www.dhs.state.ia.us/docs/Summary-IA_CoalitionIntegratedEmploymentf_082112.pdf

The focus on employment is an example of something that we value. This also demonstrates the importance of stakeholder input. Rick noted that this effort comes from stakeholders from the ID/DD world, but said that these same three indicators are what the MH world is looking at using. This example was provided to demonstrate the process that these groups went through, and can be used as a guide for this workgroup. SF2315 also wanted us to build on prior work of the Commission, and employment was an area they emphasized.

The SELN handout suggests three measures for employment that would include *type of job*, *hours worked*, and *wages earned*. The ICIE summary chose to refine the definitions of the types of employment. ICIE stakeholder coalition looks again at setting, hours worked, and gross wages. The group wants to use the data to guide decision-making about what is working or not working for the individual and for the system. By beginning with the primary indicators, we can build flexibility into your system. This allows it to evolve over time.

Public comment:

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| Comment: | I appreciate the discussion about domain and principles and values. Person centered and who's our audience, thinking about how this data is important to whom we serve. The data is evolving, I like to hear that, but once you start counting something it's set. |
| Comment: | Regarding access to employment, the SELN and ICIE stakeholder groups discussed in terms of workforce development and workforce training. |
| Response: | The system may have the same finite money but if you value or prioritize employment now, you can push the system over time to one that is more employment oriented. The use of employment outcome measure will inform how you go about that. |

Identifying *Best in Class* measures by Domain:

Workgroup members were asked to send Lauren any assessment tools that they thought would be valuable for the next meeting. The workgroup members also asked for an example of different assessment tools for the next meeting. Kevin, Bob, and Rick agreed to look at the following key pieces of today's conversation and bring examples of different measures for these domains to the next meeting.

What does "Life in the Community" mean?

- Decreased/elimination of waiting lists. It's an easy measure, and a frequent measurement in Olmstead plans.
- Number of contacts with non-family members (socialization opportunities).
- Access to transportation.
- What do people do with their leisure?
- Volunteering
- attendance at community meetings
- Engagement in activities
- Retirement ... is this maybe a "Quality of Life" measure?
- Exercise, physical activity, any of those things outside the traditional service system, how are people actively engaged in spiritual or a peer group, community or civic groups, boards, etc. Do you do that as an individual or as part of a group of people with disabilities?
- How much do you know the people around you?
- Social Inclusion

Kevin asked if anything about "prevention" resonate with the group in this domain. The group noted that prevention can come in many forms, from actually preventing illness to preventing recidivism. However, we need to be sure that a prevention activity can relate to the outcome that we want to see. For example, mental health first aid is a prevention activity and could be a process measure for crisis services.

Kevin pointed out the need to be careful when defining measures, for example: what do we mean by "integration"? HUD Sec.811 only provides rental assistance for living in settings that have less than 25% people with disabilities, that's how they define integration. Other measures are more quality of life oriented-, does a person feel like they are part of their community, does a person work in their community, etc.

Housing measures under "Life in the Community":

- Safe, decent, affordable, universal design numbers (how many new units were built with UD), proximity of those to transportation.
- Access/proximity to other services, therapist, drycleaner, grocery store. Is it a comfortable living environment?
- Need to be aware of rural areas, maybe *no one* has proximity to those services but you don't want to make people move because of it.
- How many people with disabilities do you live with (some measure of integration).
- Lease, rent, own, who signs the lease, how does anyone get access to services if they're determined eligible.
- Proximity to natural supports.
- Choice is an important factor too (ex: choosing to live in a rural community).
- The *quality* of the landlord, for people in rental situations.
- What kind of supports did they get to find housing.
- Characteristics of integrated settings: do you have privacy, do you have a key, do you have control over your living space, can you name one neighbor....
- Are there funds available for transition from institution to community housing? Is this source of funding sustainable?

- Accessibility (physically, financially)
- Satisfaction questions

Domain “Life in the Community”: Institutionalization/retention

This data is collected in a piecemeal fashion from the MHIs and State Resource Centers, Medicaid, Magellan, and the counties. It will be important to break down the silos to analyze all the data together. Part of this work will be done in the Data workgroup. They will have to figure out how to make the system information be robust enough to differentiate by individual, yet still give us a statewide view of where we are.

Domain “Life in the Community”: Social engagement/leisure/engagement in activities

These will come from surveys, asking members and family directly.

- Do you have internet connection?
- Is this area of life important to you? Of the people who reported it's important, they reported...some people may not *want* to be engaged in the community.
- The autonomy people have; were they engaging in an activity outside of the service system (of their own free will).
- Do you have someone in whom you can confide?

The group agreed that rather than identify specific indicators that may assign value to particular activities, measures could be more open and have the opportunity to be qualified. For example, do you participate in any social activities? If so, what? Have the services you receive helped you to socialize better with family and friends?

Domain “Access”

The group listed several potential indicators for measuring Access:

- Transportation times to care
- How long were you waiting? (From initial contact to service; initial screen to admission; on waitlist; for phone calls to be returned; etc.)
- Are we admitting people to the right levels of care?
- What access do you have to services when you're in crisis?
- Does crisis intervention service exist?
- Some measure of core services, are there enough of them, are they the right services?
- Access to evidence based practices.
- Did you need access to mental health services in the last six months, and could you get it when you needed it?
- Workforce availability: do we have enough of the right professionals to provide the services?
- How do you utilize the expertise in your community to be regionally administered and locally delivered?
- A “Certificate of Need” type program to determine access points
- Continuity of care is also important. If you've seen one doctor already, how can we get you back to that same doctor so we don't start all over again?
- How have you advertised or what level of advertisement do you do?
- Access to people who have information.

- “No wrong door” concept. Focus on getting consistent guidance on where to go.
- Access to care coordination
- Did you feel you could access services in your chosen language?
- Hours of operation
- Is childcare available?
- Eligibility standards – would you track how many applied who were ineligible?
- Cost
- Transportation that crosses county lines

Public Comment:

Comment: As you think about where this will go and whoever you’re seeking this information from; consider that a lot of it is perception and not necessarily hard fact. Most likely you’ll have to take further steps in digging into the information, literally manually making phone calls or on the ground searching. How far do you want to go in expanse of this stuff because it will just lead you to need to go further.

Comment: I get concerned when we look at these Regions that aren’t developed yet, and at this point there are no guarantees they’re going to get upfront dollars, and the more complex you get the more the money will get bled off for other things.

Response: We’re at a point in our workgroup work where we’re broadening the focus; we’ll get to a point when we focus in more narrowly. We’ll review the information collected today and suggest for the next meeting a condensed list of possible measures for the domains we discussed today.

For more information:

Handouts and meeting information for each workgroup will be made available at:
<http://www.dhs.state.ia.us/Partners/MHDSRedesign.html>

Website information will be updated regularly and meeting agendas, minutes and handouts for the redesign workgroups will be posted there.